STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/7/19 through 5/9/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/7/19 through 5/9/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 3 closed record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		5/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/17/2019

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F 657	Continued From page 1 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed for one of 21 residents in the survey sample (Resident # 51) to review and revise the resident's plan of care to reflect the provision of bathing. Bathing provided by the resident's family was not addressed in the plan of care. The findings were: Resident # 51 was admitted to the facility on 8/4/17 with diagnoses that included hypertension, anxiety disorder, depression, frontotemporal dementia, dizziness and giddiness. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 3/28/19, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills. Review of the Physician's Orders in Resident # 51's Electronic Health Record (EHR) revealed the following medication order dated 3/5/19:	F 657	This Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statement made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. 1. The facility failed to revise and update the care plan record of resident #51 to reflect the provision of bathing to include bathing to be provided by residents family. Resident # 51 comprehensive care plan was updated on 5/8/19 by the director of nursing to reflect family providing bath care. There were no negative affect to resident	

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F 657	Continued From page 2 Alprazolam 1 mg (milligram) tablet - 1 tablet by mouth once daily 30 minutes prior to shower as needed. There was no stop date for the PRN (as needed) order. (NOTE: Alprazolam [Xanax] is a short to intermediate acting benzodiazepine used in the treatment of anxiety, panic disorders with or without agoraphobia, and anxiety with depressive symptoms. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 41.) At 9:30 a.m. on 5/8/19, LPN # 1 (Licensed Practical Nurse) was asked about the PRN use of Alprazolam [Xanax]for Resident # 51. LPN # 1 indicated the Alprazolam [Xanax] was used to reduce the resident's anxiety prior to getting a shower. "We usually give it to her 30 to 40 minutes before her shower," LPN # 1 said. "Her daughter-in-law will call and let us know if she is coming to give her a shower. Sometimes her other daughter-in-law will call and come to give her a shower." Review of the Nurses Notes in Resident # 51's EHR revealed the following entries: 1/6/19 - 7:08 p.m. "...RP (Responsible Party) (name) in for visit and gave resident a shower...." 1/7/09 - 12:24 p.m. "...She will only take a shower with (name), RP who comes to the facility to provide showers...." 3/2/19 - 5:28 p.m. "...Resident's daughter-in-law (name of RP) in facility this shift and gave resident a shower...." 4/28/19 - 5:48 p.m. "...RP gave resident a shower this shift...." LPN # 4 provided a copy of the "Baths Roster" for	F 657	#51. 2.The Director of Nursing or designee audit all the bathing preference care plans to ensure we honoring all residents preferences. 3.The Director of Nursing or designee educated nursing staff on documenting residents preferences during showers 4. The Director of Nursing or designee will audit 10 resident care plans per week for 4 weeks. Then 5 residents weekly for a month, 10 residents monthly until compliance is met. 5. Findings or updates will be reported by the Director of nursing to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director Admissions Director, Dietary Manager Social Services Director Activities Director, Employee Relations Director, Central supply Coordinator and CNA. The Director of Nursing is responsible for ongoing compliance.	

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F 657	Continued From page 3 Resident # 51 for the period of 3/21/19 through 5/7/19. The "Baths Roster" listed the date, time, person providing bathing, and whether a shower or a bed bath was provided, or if no bath was scheduled. The Nurses Note for 4/28/19 indicated the resident's RP gave her a shower. According to the "Baths Roster" for 4/28/19, no bath was scheduled. Asked why the name of the resident's RP didn't appear on the "Baths Roster" as having given the resident a shower, LPN # 4 said, "Only bathing provided by the staff is listed, not bathing provided by the family. It isn't listed because we didn't provide it." A review of Resident # 51's care plan failed to identify a problem, goal, or intervention that addressed the provision of bathing by her family. The findings were discussed during a meeting at 4:15 p.m. on 5/8/19 that included the Administrator, the Director of Nursing, the Corporate Nurse Consultant, and the survey team.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		5/24/19

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F 689	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and clinical record review, the facility staff failed to provide assistive devices for one of 21 in the survey sample. Resident #74, who was identified as having a history of falls was observed without bilateral falls mats to each side of the bed. The findings include: Resident #74 was admitted to the facility on 04/17/12. Diagnoses included senile degeneration of the brain, dementia without behavioral disturbance, repeated falls, adult failure to thrive, dysphasia, hypertension, hyperlipidemia, depression and hospice encounter. The most recent minimum data set (MDS) dated 03/22/19 assessed Resident #74 as having long and short term memory problems, moderately impaired for daily decision making, inattention (continuous), periods of disorganized thinking (fluctuating) and periods of altered levels of consciousness (fluctuating). Further review of the 03/22/19 MDS revealed under Section G (Functional Status), Resident #74 was assessed as not walking in her room or the unit; as being totally dependent with one person assistance for locomotion on and off the nursing unit, and as totally dependent with two person assistance for bed mobility, transfers and toileting. On 05/08/2019 at 10:15 a.m., Resident #74 was observed in bed sleeping. There were two fall mats observed on the left side of the bed. One fall mat was fully extended beside the bed, the second fall mat was folded in half and laying on	F 689	1.The facility failed to provide assistive devices for resident #74. Resident to have bilateral fall mats. Resident had two fall mats but on the same side of the bed. No harm came to the resident. 2. All resident with fall mats have potential to be affected. Director of nursing/or designee did 100% audit on 5/14/19 for orders for fall mats and care plan for fall mats and that these orders were being followed. 3. Director of nursing and/or designee in-serviced licensed nursing and nursing assistants on 5/14/19 about following physician orders and care plans with properly placing fall mats. 4. The Director of nursing and or designee will continue 100% fall mat audit weekly for 4 weeks and then bi-weekly for 4 weeks and then monthly for three month. 5. Findings or updates will be reported by the Director of nursing to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director Admissions Director, Dietary Manager Social Services Director Activities Director, Employee Relations	

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F 689	Continued From page 5 top of the extended fall mat, no mat was observed on the right side of the bed. On 05/08/2019 at 10:40 a.m., Resident #74's clinical record was reviewed. The current physician order summary (POS) for May 2019 included orders carried forward from 02/26/19 for "Bilateral Fall Mats When Resident In Bed, daily for every shift." The care plan was reviewed and under the category "Falls" was noted an intervention carried forward from 05/29/18 for "Fall mats for both sides of bed." The care plan was most recently reviewed on 03/21/19. On 05/08/19 at 11:10 a.m., the certified nursing assistant (CNA #1) was interviewed regarding fall interventions for Resident #74. CNA #1 stated the resident was supposed to have fall mats on both sides of the bed. CNA #1 stated she forgot to put the fall mat down on the right side of the bed. These findings were discussed during a meeting on 05/08/19 at 4:50 p.m. with the administrator, director of nursing (DON) and the corporate nurse consultant.	F 689	Director, Central supply Coordinator and CNA. The Director of Nursing is responsible for ongoing compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		5/24/19

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F 758	Continued From page 6 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 7 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure one of 21 residents in the survey sample (Resident # 51) was free of unnecessary psychotropic medications. Resident # 51 had a physician's order for PRN (as needed) Xanax without a stop date. The findings were: Resident # 51 was admitted to the facility on 8/4/17 with diagnoses that included hypertension, anxiety disorder, depression, frontotemporal dementia, dizziness and giddiness. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 3/28/19, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills. Review of the Physician's Orders in Resident # 51's Electronic Health Record (EHR) revealed the following medication order dated 3/5/19: Alprazolam 1 mg (milligram) tablet - 1 tablet by mouth once daily 30 minutes prior to shower as needed. There was no stop date for the PRN (as needed) order. (NOTE: Alprazolam [Xanax] is a short to intermediate acting benzodiazepine used in the treatment of anxiety, panic disorders with or without agoraphobia, and anxiety with depressive symptoms. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 41.)	F 758	1. The facility failed to have PRN order for psychotropic drug limited to 14 day nor did physician document the rationale in the residents medical record or document review. 2. Resident on PRN psychotropic can be affected, The Director of Nursing or designee will do 100% audit on all residents with psychotropic medications to ensure stop date is ordered with medications. 3. The Director of Nursing or designee educated nurse practitioner and medical director of the requirement for 14 day stop date and review 4. The Director of Nursing or designee will audit 10 psychotropic medication orders every week x4 weeks, then biweekly for 8 weeks, then every month for 3 months 5. Findings or updates will be reported by the Director of nursing to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director Admissions Director, Dietary Manager Social Services Director Activities Director, Employee Relations	

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F 758	Continued From page 8 According to a review of the Electronic Medication Administration Records for the months of March, April, and as of the date of record review, for May 2019, the resident received Alprazolam [Xanax] three times; once on 3/9/19, once on 4/28/19, and once on 5/5/19. At 9:30 a.m. on 5/8/19, LPN # 1 (Licensed Practical Nurse) was asked about the PRN use of Alprazolam [Xanax]for Resident # 51. LPN # 1 indicated the Alprazolam [Xanax] was used to reduce the resident's anxiety prior to getting a shower. "We usually give it to her 30 to 40 minutes before her shower," LPN # 1 said. "Her daughter-in-law will call and let us know if she is coming to give her a shower. Sometimes her other daughter-in-law will call and come to give her a shower." The findings were discussed during a meeting at 4:15 p.m. on 5/8/19 that included the Administrator, the Director of Nursing, the Corporate Nurse Consultant, and the survey team.	F 758	Director, Central supply Coordinator and CNA. The Director of Nursing is responsible for ongoing compliance.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		5/24/19

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F 806	Continued From page 9 by: Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to accommodate resident's food preferences and intolerance's for one of 21 residents in the survey sample, Resident # 45. Resident # 45 was served food items identified on the meal ticket she disliked. Findings include: Resident # 45 was admitted to the facility 11/8/18 with diagnoses to include history of stroke, congestive heart failure, high blood pressure, diverticulosis, and heart disease. The most recent MDS (minimum data set) was a quarterly review dated 3/20/19 and had Resident # 45 coded as cognitively intact with a total summary score of 15 out of 15. During initial tour, Resident # 45 stated she has diverticulitis and is unable to eat certain foods. She stated she has discussed this "several times" with the dietary staff but continues to get foods she does not like/cannot eat. On 5/7/19 at 12:25 p.m. Resident # 45 was observed eating lunch and had a portion of corn on her tray. She stated "See? I can't eat that[corn]. I also can't eat the green pepper, but the meat came out fairly easy so I can eat that..." The resident stated that despite letting dietary staff know of her dietary preferences/restrictions related to diverticulitis, she continues to get those items on her tray "all the time." The resident's meal ticket was then reviewed. Her "Dislikes" included broccoli, green beans, peas, corn, prunes, and prune juice. The list was confirmed	F 806	1. Resident number #45 was offered other food options and she declined. 2. A 100% was completed on May 10, 2019 of all resident food dislikes by Certified Dietary Manager. All dislikes are now highlighted on the meal cards to ensure resident's get their food preferences. 3. Dietary staff was inserviced May 14,2019 through May 16,2019 by the Certified Dietary Manager on Resident's rights related to food service Creating a positive dining experience for the residents, Resident food preferences and food preferences being highlighted. 4. An audit of five trays per day for two weeks and then 5 trays two times a week for two weeks then five trays weekly will be conducted by the Certified Dietary Manager. 5. Findings or updates will be reported by the Certified Dietary Manager to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director Admissions Director, Certified Dietary Manager, Social Services Director, Activities Director, Employee Relations	

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F 806	Continued From page 10	F 806		

with the resident who stated "I like broccoli; not sure how that got on there."

On 5/7/19 at 12:40 p.m. the dietary manager (DM) was interviewed about the resident's meal. The DM stated "I'll have to get the cook for you; she plates the food." The cook, identified as OS (other staff) # 4 stated, "It was a mistake." The cook was then advised the resident stated this happens "all the time." OS # 4 stated "Well, when I'm plating food, the dietary aide tells me what is needed....whether it's a mechanical diet, pureed, or regular. They are supposed to alert me to any restrictions or dislikes so I don't put it on the tray." OS # 4 was asked where the dietary aide obtained the information. She stated "It's on the tray ticket; the ticket is on the tray, but I'm not sure who looks at it...."

On 5/8/19 at 10:00 a.m. during review of the clinical record the care plan was reviewed. The care plan, dated with a "Problem Onset" date of 2/14/19 identified "At risk for nutritional concerns related to diagnosis of GERD, diabetes, diverticulosis, dysphasia, hyperlipidemia (high cholesterol). "Approaches" included "Provide diet as ordered...Honor food preferences as available." Resident's daughter often voices food preferences for Resident. Resident often sends notes with requests."

During an end of the day meeting with facility staff beginning at 4:52 p.m. the administrator, DON (director of nursing), and corporate nurse consultant were informed of the above findings. The administrator stated "The cook didn't want to get the aide in trouble; but the process is the dietary aide is supposed to inform the cook what to put on the tray based on the meal ticket."

Director, Central supply Coordinator and CNA. The Certified Dietary Manager is responsible for ongoing compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 11 No further information was provided prior to the exit conference.	F 806		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	C 05/09/2019

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F 880	Continued From page 12 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to develop and implement a water management program to identify the risk of Legionella. Findings include:	F 880	1. The facility has not fully developed and implemented a water management program to identify the risk of Legionella. 2. All resident's are a potential for risk. On May 8, 2019 temperatures were	

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F 880	Continued From page 13 On 5/8/19 at 8:00 a.m. LPN (licensed practical nurse)# 4 was interviewed regarding the Legionella program and stated "I just became the infection preventionist; the information in the book is what I have so far; no, I don't have the risk assessment, I haven't done that...it's a work in progress...the Maintenance Director does the water temps." On 5/8/19 at 8:08 a.m. Maintenance Director, identified as OS (other staff) # 5 stated "I do the water temps in the resident room, the kitchen, and the shower room...There's a holding tank out back with gauges but I don't document the temps for that..." During an end of the day meeting with facility staff beginning at 4:52 p.m. the administrator, DON (director of nursing), and corporate nurse consultant were informed of the above findings. On 5/9/19 at approximately 7:30 a.m. the administrator presented a diagram of the facilty floor plan. She stated "I just wanted to show you where the water comes in the building, and the Maintenance Director took temps this morning in some of the holding tanks..." The administrator was advised that the CDC (Centers for Disease Control) toolkit, included in the book the ADON (assistant director of nursing) had presented, was the best source for creating a water management system. The administrator stated she would have staff responsible for the water management get started "immediately" to correct the deficient practice. No further information was provided prior to the exit conference.	F 880	obtained of incoming water, the water boiler, the water fountain and showers by the Maintenance Director. Temperatures were found to be within the desired range (lower than 65 or higher than 145). No residents have or have had legionnaires disease. 3. A water management program to identify the risk of Legionella will be fully developed and implemented by May 24, 2019. The Maintenance Director, ADON, Director of Nursing were inserviced on May 21, 2019 by the administrator on execution of a legionella water management program as directed by CMS to reduce legionella risk in the facility water systems to prevent outbreaks of legionnaires disease. 4. The administrator will audit the established control points on a weekly basis for 1 month and monthly thereafter to ensure control measures and limits are met. 5. Findings or updates will be reported by the Administrator to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director Admissions Director, Dietary Manager Social Services Director Activities Director, Employee Relations	

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F 880	Continued From page 14	F 880	Director, Central supply Coordinator and CNA. The Administrator is responsible for ongoing compliance.	